

MDR Tracking Number: M5-04-3202-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 24, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The **office visits (99213), electrical stimulation (97032), and manual therapy technique (97140)** for dates of service 05/21/03 through 10/23/03, and **physical performance test/measurements (97750)** for dates of service 06/04/03, 07/30/03, and 09/03/03, were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits, electrical stimulation, manual therapy technique and physical performance test/measurements for dates of service listed.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

On July 13, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

Special reports (**99080-73**) for dates of service 07/03/03 and 09/15/03 denied as "V" and a physical performance test/measurement (**97750**) for date of service 10/14/03 denied as "S – Supplement payment".

- CPT Code 99080-73 – The carrier denied the Work Status Report for unnecessary medical treatment based on a physician retrospective review report, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Per Rule 133.307(e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration were not submitted; therefore, services can not be confirmed they were rendered as billed. Reimbursement is not recommended.
- CPT Code 97750 (4 units) – The carrier submitted a supplemental payment to the healthcare provider in the amount of \$29.55. Per Rule 133.307(e)(2)(A) a copy of all medical bills as originally submitted to the carrier for reconsideration were not submitted; therefore, services can not be confirmed they were rendered as billed. Additional reimbursement is not recommended.

As the **office visits (99213), electrical stimulation (97032), manual therapy technique (97140), and physical performance test/measurements (97750)** were not found to be medically necessary and based on the review of the fee issues within the request the Division declines to issue an Order for dates of service 05/21/03 through 10/23/03.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision is hereby issued this 8th day of October, 2004

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf

Enclosure: IRO decision

## NOTICE OF INDEPENDENT REVIEW DECISION

August 18, 2004

**Amended Letter 10/01/04**

Rosalinda Lopez  
Program Administrator  
Medical Review Division  
Texas Workers Compensation Commission  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Injured Worker:  
MDR Tracking #: M5-04-3202-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308, which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient is a 53 year-old male who, on \_\_\_\_, injured his right shoulder after lifting 70- pound boxes. He initially felt a pull followed by immediate onset of right shoulder pain. He was initially treated by the company doctor, but eventually changed to a doctor of chiropractic medicine and began care on 02/14/03. Since that time, treatment has included chiropractic and physical therapy.

### Requested Service(s)

Level III office visits, electrical stimulation, physical performance testing or measurement, and manual therapy technique for dates of service 05/30/03 through 10/23/03

### Decision

It is determined that level III office visits, electrical stimulation, physical performance testing or measurement, and manual therapy technique were not medically necessary to treat this patient's medical condition from 05/30/03 through 10/23/03.

### Rationale/Basis for Decision

The doctor of chiropractic had been treating this patient in this same fashion since 02/14/03, more than 3 months before the dates in this dispute began. The doctor's records reveal that the patient not only failed to respond symptomatically, his range of motion also remained the same throughout the prescribed care. In fact, some motions actually worsened during the time frame in dispute. There is no basis to proceed with a therapy plan that was not providing significant benefit. Moreover, since the prescribed care failed to relieve the patient's symptoms, promote recovery, or enhance his ability to return to work, it did not meet the statutory requirements of Labor Code 408.021 and was not considered medically necessary. Therefore, it is determined that level III office visits, electrical stimulation, physical performance testing or measurement, and manual therapy techniques were not medically necessary to treat this patient's medical condition from 05/30/03 through 10/23/03.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:vn

Attachment